FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015784

Facility Name: Walnut Manor

Address: 308 South Second Street (Number) Walnut (City) 61376 (Zip Code)

County: Bureau

Telephone Number: (815) 379-2131 **Fax #** ( )

IDPA ID Number: 362739492001

Date of Initial License for Current Owners: 07/13/73

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		xx	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2001 to 09/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Dennis Grobe
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) CRAIG L. ATER
(Firm Name & Address) Heritage Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	0	Skilled (SNF)	0	0	1
2		Skilled Pediatric (SNF/PED)			2
3	62	Intermediate (ICF)	62	22,630	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,630	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,080	9,583	0	19,663	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	10,080	9,583		19,663	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.89%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 07/13/73

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 07/13/73 NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [xx] If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Walnut Manor # 0015784 **Report Period Beginning:** 10/01/2001 **Ending:** 09/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	137,274	17,027		154,301		154,301		154,301			1
2	Food Purchase		103,016		103,016		103,016		103,016			2
3	Housekeeping	49,947	8,788		58,735		58,735		58,735			3
4	Laundry	57,765	10,407		68,172		68,172		68,172			4
5	Heat and Other Utilities			48,898	48,898		48,898		48,898			5
6	Maintenance	28,392	27,647	11,328	67,367		67,367		67,367			6
7	Other (specify):*											7
8	**TOTAL General Services**	273,378	166,885	60,226	500,489		500,489		500,489			8
	B. Health Care and Programs											
9	Medical Director			650	650		650		650			9
10	Nursing and Medical Records	781,627	50,815	29,810	862,252		862,252		862,252			10
10a	Therapy			2,591	2,591		2,591		2,591			10a
11	Activities	49,359	3,719	3,408	56,486		56,486		56,486			11
12	Social Services	9,757	233	1,005	10,995		10,995		10,995			12
13	Nurse Aide Training	3,585	835		4,420		4,420		4,420			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	844,328	55,602	37,464	937,394		937,394		937,394			16
	C. General Administration											
17	Administrative	48,381			48,381		48,381		48,381			17
18	Directors Fees			4,540	4,540		4,540		4,540			18
19	Professional Services			112,000	112,000		112,000	(23,783)	88,217			19
20	Dues, Fees, Subscriptions & Promotions			53,491	53,491	(33,945)	19,546	(6,597)	12,949			20
21	Clerical & General Office Expenses	37,043	13,238	8,004	58,285		58,285		58,285			21
22	Employee Benefits & Payroll Taxes			217,103	217,103		217,103		217,103			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,708	8,708		8,708	(6,709)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,328	26,328		26,328		26,328			26
27	Other (specify):*			70	70		70	(70)				27
28	**TOTAL General Administration**	85,424	13,238	430,244	528,906	(33,945)	494,961	(37,159)	457,802			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,203,130	235,725	527,934	1,966,789	(33,945)	1,932,844	(37,159)	1,895,685			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Walnut Manor #0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			22,965	22,965		22,965		22,965			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,716	15,716		15,716	(115)	15,601			32
33	Real Estate Taxes			33,300	33,300		33,300		33,300			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			721	721		721	(41)	680			35
36	Other (specify):*											36
37	**TOTAL Ownership**			72,702	72,702		72,702	(156)	72,546			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		824	11,467	12,291		12,291		12,291			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					33,945	33,945		33,945			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		824	11,467	12,291	33,945	46,236		46,236			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,203,130	236,549	612,103	2,051,782		2,051,782	(37,315)	2,014,467			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(41)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(115)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment	(6,709)	24		19
20	Contributions	(70)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,783)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,597)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,315)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (37,315)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Walnut Manor

ID# 0015784

Report Period Beginning: 10/01/2001

Ending: 09/30/2002

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		$	0	0	1
2			0	0	2
3			0	0	3
4			0	0	4
5			(41)	35	5
6			0	34	6
7			0		7
8			0		8
9			0	30	9
10				32	10
11			0		11
12			0		12
13			0	2	13
14			0	32	14
15			0	33	15
16			0	24	16
17			0	20	17
18			0		18
19				24	19
20			(70)	27	20
21			0		21
22			(23,783)	19	22
23			0		23
24			0	27	24
25			(6,597)	20	25
26			0	0	26
27			0	0	27
28			0	0	28
29			0	0	29
30			0	0	30
31			0	0	31
32					32
33			0	33	33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	**Total**		(30,491)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walnut Manor # 0015784 **Report Period Beginning:** 10/01/2001 **Ending:** 09/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,783)	0	0	0	0	0	0	0	0	0	0	(23,783)	19
20	Fees, Subscriptions & Promotions	(6,597)	0	0	0	0	0	0	0	0	0	0	(6,597)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,709)	0	0	0	0	0	0	0	0	0	0	(6,709)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(70)	0	0	0	0	0	0	0	0	0	0	(70)	27
28	**TOTAL General Administration**	(37,159)	0	0	0	0	0	0	0	0	0	0	(37,159)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,159)	0	0	0	0	0	0	0	0	0	0	(37,159)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walnut Manor # 0015784 **Report Period Beginning:** 10/01/2001 **Ending:** 09/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(115)	0	0	0	0	0	0	0	0	0	0	(115)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(41)	0	0	0	0	0	0	0	0	0	0	(41)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(156)	0	0	0	0	0	0	0	0	0	0	(156)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(37,315)	0	0	0	0	0	0	0	0	0	0	(37,315)	45

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Thomas Garland	President	Board Member	1.11		1		Board Mtg	$ 540	line 18	1
2	Tony Zueger	Vice President	Board Member	3.33		1		Board Mtg	560	line 18	2
3	Brooke Haurberg	Director	Board Member	5.55		1		Board Mtg	560	line 18	3
4	Dennis Grobe	Director	Board Member	1.11		40	100.00	Board Mtg/Admi	48,381	line 17/18	4
5	Lyne Anderson	Director	Board Member	4.44		1		Board Mtg	560	line 18	5
6	Bruce Atherton	Director	Board Member	1.11		1		Board Mtg	540	line 18	6
7	Steve Schlumpf	Director	Board Member	0.00		1		Board Mtg	560	line 18	7
8	Kent Siltman	Director	Board Member	0.00		1		Board Mtg	600	line 18	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 52,301		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 9/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [xx]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$ 658,566			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Walnut Comm Develop	xx		Working Capital			70,000	85,000			5,505	6
7	Citizens First State		xx	Working Capital				153,000			10,211	7
8												8
9	TOTAL Facility Related						$ 70,000	$ 896,566			$ 15,716	9
	B. Non-Facility Related*											
10	Interest Income										(115)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (115)	14
15	TOTALS (line 9+line14)						$ 70,000	$ 896,566			$ 15,601	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	31,521	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,926	2
3. Under or (over) accrual (line 2 minus line 1).	$	405	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	32,895	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	33,300	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walnut Manor COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0015784

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309)823-7135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0317100003	Nursing Home	$ 40,041.00	$ 33,300.00
2.	0317202001	Nursing Home	$ 165.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,206.00	$ 33,300.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 20,610	1
2					2
3	TOTALS			$ 20,610	3

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62				$ 469,470	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1977	1,605						9
10	Improvements			1979	15						10
11	Improvements			1978	3,737						11
12	Improvements			1980	12,962						12
13	Improvements			1981	6,721						13
14	Improvements			1982	2,572						14
15	Improvements			1983	1,394						15
16	Improvements			1984	10,068						16
17	Improvements			1985	2,599						17
18	Improvements			1988	6,911						18
19	Improvements			1991	15,262						19
20	Improvements			1992	28,595						20
21	Improvements			1993	8,420						21
22	Improvements			1994	12,336						22
23	Improvements			1995	14,430						23
24	Chair rail			1996	6,870						24
25	Tile			1996	1,131						25
26	Door Frames			1996	2,345						26
27	Cabinets			1998	4,228						27
28	Bathroom Remodeling			1999	8,243						28
29	Med Room Improvements			1999	4,922						29
30	Wander Guard System			2000	760						30
31	Fire Alarm			2000	675						31
32	Main Entrance Alarm			2000	2,422						32
33	Drapes			2001	1,126						33
34	Fire Doors			2001	2,255						34
35	Book Depreciation					14,898		14,898		563,538	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Living Room Railing	2001	$ 444	$		$	$	$	37
38	Drapes	2001	967						38
39									39
40	Improvements	1973	22,000						40
41	Improvements	1976	1,055						41
42	Improvements	1978	73						42
43	Improvements	1980	48						43
44	Improvements	1982	1,616						44
45	Improvements	1983	1,330						45
46	Improvements	1984	213						46
47	Improvements	1985	11,880						47
48	Improvements	1988	400						48
49	Improvements	1995	8,735						49
50									50
51	Retention Pond	1997	7,565						51
52									52
53	Improvements	1978	53,783						53
54	Improvements	1979	1,207						54
55	Improvements	1982	105						55
56	Improvements	1984	310						56
57	Improvements	1985	1,107						57
58	Improvements	1986	570						58
59	Improvements	1987	1,811						59
60	Improvements	1988	575						60
61	Improvements	1989	3,412						61
62	Improvements	1990	10,184						62
63	Improvements	1991	3,193						63
64	Improvements	1994	11,944						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 776,601	$ 14,898		$ 14,898	$	$ 563,538	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 776,601	$ 14,898		$ 14,898	$	$ 563,538	1
2									2
3	Cabinets	1998	3,647						3
4	Bathroom Fixtures	1999	18,379						4
5	Doors	1999	4,900						5
6	Furnace	2001	1,527						6
7	Air Conditioner	2001	1,435						7
8									8
9	Smoke Detector	2002	2,754						9
10	Emergency Lights	2002	1,188						10
11	Fire Dampers	2002	6,455						11
12	Insulated Door	2002	635						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 817,521	$ 14,898		$ 14,898	$	$ 563,538	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 225,617	$ 8,067	$ 8,067	$		$ 190,453	71
72	Current Year Purchases	7,718						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 233,335	$ 8,067	$ 8,067	$		$ 190,453	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Ford Van	1989	$ 32,704	$	$	$		$ 32,704	76
77										77
78										78
79										79
80	TOTALS			$ 32,704	$	$	$		$ 32,704	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,104,170	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,965	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,965	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 786,695	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living Center	$ 595,532	$ 25,218	$ 136,827	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 595,532	$ 25,218	$ 136,827	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 680 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		835		835
3	Classroom Wages (a)		3,585		3,585
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 4,420	$	$ 4,420
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,420			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 0	$		$	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			2,591			2,591	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				0				13
14	TOTAL			$		$ 2,591	$		$ 2,591	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 21,001	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	173,817		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,824		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 225,642	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,610		13
14	Buildings, at Historical Cost	1,241,299		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	381,373		16
17	Accumulated Depreciation (book methods)	(978,128)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Tax Asset	14,236		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 679,390	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 905,032	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 80,541	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,185		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,931		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,895		32
33	Accrued Interest Payable	1,838		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	25,052		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 183,442	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	658,566		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 658,566	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 842,008	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 63,024	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 905,032	$	48

***(See instructions.)**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 160,105	1
2	Restatements (describe):		2
3	Audit Adjustment	(2,310)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 157,795	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(52,326)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Loss from Non-Nursing property	(42,445)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (94,771)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 63,024	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,008,624	1
2	Discounts and Allowances for all Levels	(28,180)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,980,444	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,268	12
13	Barber and Beauty Care	13,320	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	487	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,075	23
	D. Non-Operating Revenue		
24	Contributions	3,822	24
25	Interest and Other Investment Income***	115	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,937	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,999,456	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	500,489	31
32	Health Care	937,394	32
33	General Administration	528,906	33
	B. Capital Expense		
34	Ownership	72,702	34
	C. Ancillary Expense		
35	Special Cost Centers	12,291	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Loss from Non-Nursing property	42,445	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,094,227	40
41	**Income before Income Taxes (line 30 minus line 40)****	(94,771)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (94,771)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,776	2,080	$ 41,697	$ 20.05	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,918	6,272	116,547	18.58	3
4	Licensed Practical Nurses	11,742	12,974	204,778	15.78	4
5	Nurse Aides & Orderlies	35,282	38,774	418,605	10.80	5
6	Nurse Aide Trainees	303	303	3,585	11.83	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	3,252	3,716	49,359	13.28	10
11	Social Service Workers	2,042	2,152	9,757	4.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,694	17,908	137,274	7.67	15
16	Dishwashers					16
17	Maintenance Workers	3,096	3,320	28,392	8.55	17
18	Housekeepers	6,668	7,184	49,947	6.95	18
19	Laundry	8,572	8,952	57,765	6.45	19
20	Administrator	2,080	2,080	48,381	23.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,960	3,920	37,043	9.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,385	109,635	$ 1,203,130 *	$ 10.97	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		650		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,760		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,005		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 3,415		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		27,979		52
53	TOTAL (lines 50 - 52)		$ 27,979		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dennis Grobe	Administrator	0	$ 48,381
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,381

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 73,288
Clifton Gunderson	Accounting	14,929
		0
Duane Morris	Legal	23,783
Legal Fees (Adjusted to zero)		0
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 112,000

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,034
Unemployment Compensation Insurance	3,233
FICA Taxes	92,039
Employee Health Insurance	86,392
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	443
Employee Benefits -	1,962
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 217,103

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	966
Health Care Worker Background Check	
(Indicate # of checks performed 14)	136
Central Office Allocation	
Promotional Advertising	1,931
Public Relations	4,666
Dues and Subscriptions	11,849
License and Fees	(2)
Less: Public Relations Expense	(4,666)
Non-allowable advertising	(0)
Yellow page advertising	(1,931)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,949

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,853
	6
Seminar Expense	3,849
Non Allowable	(6,709)
Central Office Allocation	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Walnut Manor # 0015784 Report Period Beginning: 10/01/2001 Ending: 09/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **no** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **33,945**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **5,499**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount								
1009			PETTY CASH	21,001						1,009		21,001					
1010			CASH IN BANK							1,100		173,817					
1040			CASH IN BANK-PAYROLL							1,101							
1100			ACCOUNTS RECEIVABLE	173,817						1,105							
1110			MEDICARE RECEIVABLES							1,110							
1125			IPA INCOME RECEIVABLE							1,125							
1130			MEDICARE COST REPORT							1,130							
1135			ACCOUNTS RECEIVABLE-IC							1,135							
1140			UNAPPLIED CASH RECEIPTS							1,140							
1145			A/R SUSPENSE-REFUNDS							1,145							
1190			ACCRUED INTEREST REC							1,200		30,824					
1200			PREPAID INSURANCE	30,824						1,220							
1220			OTHER PREPAID EXPENSES							1,300							
1300			FOOD INVENTORY							1,310							
1310			SUPPLIES INVENTORY							1,320							
1409			LAND	20,610						1,409		20,610					
1450			FURNITURE & EQUIPMENT	381,373						1,450		381,373					
1460			ACCUM DEPR-FURN & EQUIP	-356,876						1,460		-356,876					
1475			BUILDING & IMPROVEMENTS	1,241,299						1,475		1,241,299					
1490			ACCUM DEPR-BUILDING	-621,252						1,490		-621,252					
1530			RESIDENT FUNDS	0						1,530		0					
1550			LOAN FEES	14,236						1,550							
1560			REAL ESTATE TAX ESCROW							1,551		14,236					
1575			REIMBURSABLE PURCHASES							1,575							
1850			INTRACOMPANY	0						1,850							
2010			ACCOUNTS PAYABLE	-80,541						2,010		-80,541					
2095			BONUSES PAYABLE							2,095							
2100			ACCRUED PAYROLL	-33,185						2,100		-33,185					
2110			ACCRUED VACATION PAY	0						2,100							
2120			UC TAXES PAYABLE							2,100							
2125			FICA TAX PAYABLE	-9,931	-9,931					2,100							
2130			FIT PAYABLE							2,110		0					
2140			STATE W/H PAYABLE		-25,052					2,120							
2145			EARNED INCOME CREDIT							2,125		-9,931					
2150			UC FED CREDIT REDUCTION							2,130							
2230			PAYROLL SAVINGS							2,140							
2235			IRA W/HOLDINGS							2,145							
2240			UNITED WAY							2,152							
2245			GROUP INSURANCE PAYABLE							2,225							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							2,230							
2260			WAGE GARNISHMENTS							2,235							
2280			MISC PAYROLL DEDUCTIONS							2,240							
2300			ACCRUED INTEREST PAYABLE	-1,838						2,246							
2310			SALES TAX PAYABLE							2,250							
2320			IPA PAYMENTS PAYABLE	0						2,260							
2350			REAL ESTATE TAX PAYABLE	-32,895						2,300		-1,838					
2385			ACTIVITY FUND	-25,052						2,320							
2390			SECURITY DEPOSITS							2,350		-32,895					
2391			VOLUNTEER FUND							2,385		-25,052					
2393			HEART FUND/BAZAAR							2,391							
2395			DEFERRED INC EMP & MEM							2,393							
2400			CURRENT PORTION LT DEBT							2,395							
2460			INCOME TAXES PAYABLE							2,400							
2512			DUE TO RESIDENTS	0						2,512		0					
2600			MORTGAGE PAYABLE	-658,566						2,600		-658,566					
2650			EQUIPMENT LOAN PAYABLE							2,600							
2695			CURRENT PORTION LT DEBT							2,625							
2696			DEFERRED INCOME TAXES							2,625							
2710			COMMON STOCK							2,695							
2720			RETAINED EARNINGS	-157,795						2,720		-157,795					
2970			PROFIT/LOSS FOR PERIOD	94,771							NI	94,771					
3007.1			PATIENT DAYS-PRIVATE	9,583								0	3,007	3007	PATIENT I	9,583	
3007.2			PATIENT DAYS-IPA	10,080									3,007	3007	PATIENT I	10,080	
3007.3			PATIENT DAYS-MEDICARE	0									3,007	3007	PATIENT DAYS-MEDICARE		
3007.4			PATIENT DAYS-CONVERSION										3,007				
3007.5			PATIENT DAYS-LICENSED										3,007				
3007.6			PATIENT DAYS-TOTAL										3,007				
3010		1	BASIC CHARGE-PRIVATE & VA	-1,117,976		0	0	0	0				3,007				
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0				3,010	3,010	BASIC CH.	-1,117,976	
3020		1	BASIC CHARGE-IPA	-864,222		0	0	0	0				3,015				
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0				3,020	3,020	BASIC CH.	-864,222	
3035		4	DAY CARE/HOME CARE			0	0	0	0				3,030				
3040		1	LIGHT NURSING CARE	0		0	0	0	0				3,035	3,030	BASIC CHARGE-MEDICARE		
3050		1	MEDIUM NURSING CARE			0	0	0	0				3,040				
3060		1	HEAVY NURSING CARE			0	0	0	0				3,050				
3061		1	SKILLED NURSING CARE										3,060				
3080		1	NURSING SUPPLIES-PRIVATE	-26,426		0	0	0	0				3,061				
3081		1	NURSING SUPPLIES-IPA			0	0	0	0				3,080	3,080	NURSING	-26,426	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0				3,081	3,081	NURSING SUPPLIES-IPA		
3083		1	NURSING SUPPLIES MED PT B										3,082	3,082	NURSING SUPPLIES-M/C A		
3100		17	DRUGS	0		0	0	0	0				3,083	3,083	NURSING SUPPLIES-M/C B		
3101		17	DRUGS-OTHER										3,100	3,100	DRUGS-MEDICARE		
3110		6	PT-PRIVATE	0		0	0	0	0				3,101	3,101	DRUGS-OTHER		
3111		6	PT-IPA			0	0	0	0				3,110	3,110	PHYSICAL THERAPY-PRIVATE		
3112		6	PT-MEDICARE PART A			0	0	0	0				3,111	3,111	PHYSICAL THERAPY-IPA		
3113		6	PT-MEDICARE PART B			0	0	0	0				3,112	3,112	PHYSICAL THERAPY-M/C A		
3130		1	PUBLIC AID ASSESSMENT INC										3,113	3,113	PHYSICAL THERAPY-M/C B		
3140		19	LABORATORY INCOME			0	0	0	0				3,130				
3150		6	SPEECH/OT-PRIVATE			0	0	0	0				3,140	3,140	LABORATORY INCOME		
3151		6	SPEECH/OT-IPA			0	0	0	0				3,150	3,150	ST/OT THERAPY-PRIVATE		
3152		6	SPEECH/OT-MED PART A			0	0	0	0				3,151	3,151	ST/OT THERAPY-IPA		
3153		6	SPEECH/OT MED PART B										3,152	3,152	ST/OT THERAPY-M/C A		
3410		2	IPA DISCOUNTS	28,180		0	0	0	0				3,153	3,153	ST/OT THERAPY-M/C B		
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0				3,160	3,160	X-RAY SERVICES INCOME		
3420		2	MEDICARE DISCOUNTS			0	0	0	0				3,410	3,410	IPA/OTHEI	28,180	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0				3,411	3,411	MEDICARE PT B-DISCOUNT		
3520		16	RENT INCOME	0		6	0	6	0				3,415				
3530		13	BEAUTY SHOP	-13,320		0	0	0	0				3,420	3,420	MEDICARE DISCOUNTS		
3560		12	ACTIVITY FUND INCOME	-367		0	0	0	0				3,440				
3570		12	VENDING INCOME/EXPENSE	-901		0	0	0	0				3,450				
3580		12	MANAGEMENT FEES			0	0	0	0				3,460				
3590		1	EQUIPMENT RENTAL	0		0	0	0	0				3,500				
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0				3,520	3,525	CONTRIBUTIONS INCOME		
3600		21	MISC INCOME	-487		0	0	0	0				3,530	3,530	BEAUTY S	-13,320	
4110		527,670	GENERAL & ADMINIST WAGES	37,043	37,043	21	1	17	0				3,560			-367	
4111			ADMINISTRATOR WAGES	48,381	48,381	17	1	0	0				3,570	3,570	VENDING	-826	
4115			VACATION & SICK - G&A	0		21	1	0	0				3,580	3,575	MANAGEI	-75	
4120	4475		EMPLOYEE BENEFITS	1,962	217,103	22	3	0	0				3,590	3,590	EQUIPMENT RENTAL		
4125			EMPLOYEE HEPETITIS VACCIN	443		22	3	0	0				3,595	3,595	RESIDENT TRANSPORTATION		
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0				3,600	3,600	MISC INC(	-487	-1,995,519
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0				4,110	4,110	G&A WAG	37,043	
4220			DIRECTORS FEES			18	3	0	0				4,111	4,111	ADMINIST	48,381	
4250	4255		OFFICE SUPPLIES	13,086	13,238	21	2	0	0				4,115	4,115	G&A PTO & RESERVE		
4260			TELEPHONE	8,004	8,004	21	3	0	0				4,120	4,120	EMPLOYE	1,609	
4275			TRAINING & EMPLOYEE DEVL	0	0	23	3	16	0				4,125			443	
4280			GENERAL TRAVEL	4,853	8,708	24	3	16	0				4,130				
4281			MEAL EXPENSE FOR TRAVEL	6		24	3	19	0				4,135	4,135	EMPLOYEE SCHOLARSHIPS-COSTS		
4285			EDUCATION & SEMINAR	3,849		24	3	19	-6,709 **				4,245	4,245	TEMPS/CONTRACT SERVICES-ADMIN		
4290			HELP WANTED ADVERTISING	966	53,491	20	3	0	0	-33,945			4,250	4,250	OFFICE SU	10,239	
4291			PROMOTIONAL ADVERTISING	1,931		20	3	25	-1,931				4,255	4,255	POSTAGE	861	
4292			PUBLIC RELATIONS	4,666		20	3	25	-4,666				4,260	4,260	TELEPHO!	8,004	
4300			LICENSES & FEES	33,943		20	3	17	0 **				4,275	4,275	TRAINING & EMPLOYEE DEVELOP		
4310			DUES & SUBSCRIPTIONS	11,849		20	3	17	0 **				4,276				
4320			CONTRIBUTIONS	70		27	3	20	-70				4,280	4,280	GENERAL	4,853	
4350			PROFESSIONAL FEES	38,712	112,000	19	3	22	-23,783 **				4,281			6	
4355			MEDICAL DIRECTOR	650	650	9	3	0	0				4,285	4,285	EDUCATI(	3,782	
4360			UTILIZATION REVIEW	0		10	3	0	0				4,289	4,286	EDUCATI(	67	
4361			OTHER PHYSICIAN FEES	0		39	3	0	0				4,290	4,290	HELP WA!	966	
4362			MEDICAL RECORDS CONSULT	0		10	3	0	0				4,291	4,291	PROMOTI(	1,931	
4363			PHARMACIST FEES	1,760		10	3	0	0				4,292	4,292	PUBLIC RI	4,666	
4364			SOC SERV/ACT CONSULT	1,005	1,005	12	3	0	0				4,300	4,300	LICENSE &	33,943	
4370			TV RENTAL	41		35	3	5	-41				4,310	4,310	DUES & SU	11,849	
4380			INCOME TAXES		70	27	3	26	0				4,320	4,320	CONTRIBU	70	
4383			BACKGROUND CHECKS	136		20	3	26	0				4,350	4,340	PASTORAI	38,712	
4400			PAYROLL TAXES	92,787		22	3	0	0				4,355	4,355	MEDICAL	650	
4401			PAYROLL TAXES ADMINIST	2,485		22	3	0	0				4,360				
4410			GROUP INSURANCE	86,392		22	3	0	0				4,361				
4420			LIABILITY INSURANCE	26,328	26,328	26	3	0	0				4,362	4,362	MEDICAL RECORDS		
4425			INSURANCE-OWNERS			22	3	21	0				4,363	4,363	PHARMAC	1,760	
4430			WORKMENS COMP INSURANCI	33,034		22	3	0	0				4,364	4,364	SOCIAL SI	1,005	
4450			CENTRAL OFFICE FEES	73,288		19	3	34	0				4,370	4,370	TV RENTA	41	
4460			BAD DEBTS	0		27	3	24	0				4,383	4,383	BACKGRO	136	
4470			LOST ITEMS-RESIDENTS	0		27	3	0					4,390			1,959	
4490			MISCELLANEOUS			27	3	0	0				4,400	4,400	PAYROLL	90,828	
4510		149,565	REAL ESTATE TAXES	33,300	33,300	33	3	0	0				4,401	4,401	PAYROLL	2,485	
4600			LEASED EQUIPMENT	0	41	35	3	16	0				4,410	4,410	GROUP IN	86,392	
5110			MAINTENANCE SALARIES	28,392	28,392	6	1	0	0				4,420	4,420	LIABILITY	26,328	
5120			MAINTENANCE SICK & VAC	0		6	1	0	0				4,430	4,430	WORKMA!	33,034	
5130			ELECTRIC	25,499	48,898	5	3	0	0				4,435	4,435	W/C-FIRST AID CLAIMS		
5131			NATURAL GAS	12,795		5	3	0	0				4,436				
5132			HEATING & DEISEL OIL			5	3	0	0				4,440				
5133			WATER & SEWER	10,604		5	3	0	0				4,450	4,450	MANAGEI	73,288	
5134			TRASH COLLECTION	2,065	11,328	6	3	0	0				4,460	4,460	BAD DEBTS		
5140			PROPERTY PLANT REPLACEMI	1,010	27,647	6	2	0	0				4,461	4,461	BAD DEBTS		
5160			GENERAL REPAIR & MAINT	26,637		6	2	0	0				4,470				
5165			MAINTENANCE CONTRACTS	9,263		6	3	0	0				4,475	4,475	UNIFORM	353	
5210		257,317	DIETARY WAGES	137,274	137,274	1	1	0	0				4,486	4,486	SERVICE (	5,563	
5220			DIETARY SICK & VAC	0		1	1	0	0				4,490	4,490	MISC EXPI	0	
5240			dietary consult	0	0	2	3	13	0				4,496			1,986	
5248			FOOD PURCHASES	108,515	103,016	2	2	0	0				4,510			33,300	
5250			SUPPLIES-DISHWASHING	1,465	17,027	1	2	0	0				4,600	4,600	LEASED EQUIPMENT		
5260			DIETARY REPLACEMENT	1,295		1	2	0	0				5,110	5,110	MAINTEN.	28,392	
5270			KITCHEN SUPPLIES-PAPER	14,267		1	2	0	0				5,120	5,120	MAINTENANCE PTO & RESERVE		
5295			MEAL CREDIT	-5,499		2	2	0	0				5,130	5,130	ELECTRIC	25,499	
5310		68,172	LAUNDRY WAGES	57,765	57,765	4	1	0	0				5,131	5,131	NATURAL	12,795	
5340			LAUNDRY SICK & VAC	0		4	1	0	0				5,133	5,133	WATER &	10,604	
5370			LAUNDRY REPLACEMENT	64	10,407	4	2	0	0				5,134	5,134	TRASH CC	2,065	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0				5,140	5,140	PROP/PLA	1,010	
5390			LAUNDRY SUPPLIES	10,343		4	2	0	0				5,160	5,160	GENERAL	26,637	
5410		58,735	HOUSEKEEPING WAGES	49,947	49,947	3	1	0	0				5,165	5,165	MAINTEN.	3,700	
5440			HOUSEKEEPING SICK & VAC	0		3	1	0	0				5,166				
5480			HOUSEKEEPING SUPPLIES	1,660	8,788	3	2	0	0				5,210	5,210	DIETARY '	137,274	
5490			HOUSEKEEPING SUPPLIES-PPR	7,128		3	2	0	0				5,220	5,220	DIETARY PTO & RESERVE		
6010		864,912	RN WAGES-MEDICARE		781,627	10	1	0	0				5,240				
6020			RN WAGES-NON MEDICARE	116,547		10	1	0	0				5,245				
6030			DON WAGES	41,697		10	1	0	0				5,248	5,248	FOOD PUR	108,515	
6035			ADON	0		10	1	0	0				5,250	5,250	SUPPLIES	1,465	
6040			RN SICK & VACATION	0		10	1	0	0				5,260	5,260	REPLACEI	1,295	
6110			LPN WAGES-MEDICARE			10	1	0	0				5,270	5,270	KITCHEN	14,267	
6120			LPN WAGES-NON MEDICARE	204,778		10	1	0	0				5,295	5,295	MEAL INC	-5,499	
6130			LPN WAGES OTHER			10	1	0	0				5,310	5,310	LAUNDRY	57,765	
6140			LPN SICK & VACATION	0		10	1	0	0				5,340	5,340	LAUNDRY PTO & RESERVE		
6210			AIDE WAGES-MEDICARE			10	1	0	0				5,370	5,370	REPLACEI	64	
6220			AIDE WAGES-NON MEDICARE	418,605		10	1	0	0				5,380	5,380	OUTSIDE I	1,223	
6230			WARD CLERKS			10	1	0	0				5,390	5,390	SUPPLIES	9,120	
6240			AIDE VACATION & SICK	0		10	1	0	0				5,410	5,410	HOUSEKE	49,947	
6245			CONTRACT NURSES-RN	0		10	3	0	0				5,440	5,440	HOUSEKEEPING PTO & RESERVE		
6246			CONTRACT NURSES-LPN	0		10	3	0	0				5,480	5,480	SUPPLIES-	1,660	
6247			CONTRACT NURSES-AIDES	27,979		10	3	0	0				5,490	5,490	SUPPLIES-	7,128	
6250			NURSE AIDE TRAINING WAGES	3,585	3,585	13	1	0	0				6,010				
6255			NURSE AID TRAINING EXP	835	835	13	2	0	0				6,020	6,020	RN WAGE	116,547	
6260			NURSE AIDE TRAINING REIMB			0	0	0	0				6,030	6,030	DON WAG	41,697	
6270			REHAB WAGES	0		10	1	0	0				6,035	6,035	ADON WAGES		
6275			REHAB SICK & VAC	0		10	1	0	0				6,040	6,040	RN PTO & RESERVE		
6280			NURSING DEPT EDUCATION			23	3	0	0				6,110				
6290			NURSING SUPPLIES	38,566	50,815	10	2	0	0				6,120	6,120	LPN WAGI	204,778	
6295			NURSING SUPPLIES	11,091		10	2	0	0				6,130				
6390			REPLACEMENT-NURSING	1,158		10	2	0	0				6,140	6,140	LPN PTO & RESERVE		
6490			NURSING OTHER	71	29,810	10	3	0	0				6,210				
7280			DRUG PURCHASES	0	0	39	2	0	0 ***				6,220	6,220	AIDES WA	418,605	
7281			DRUG PURCHASES-OTHER	0		39	2						6,230				
7380			LABORATORY SERVICES	0	2,591	39	3	0	0				6,240	6,240	AIDES PTO & RESERVE		
7410			HOME HEALTH SALARY			39	1	0	0				6,245	6,245	CONTRACT NURSES-RN		
7440			HOME HEALTH SICK & VAC			39	1	0	0				6,246	6,246	CONTRACT NURSES-LPN		
7450			HOME HEALTH EXPENSES			39	3	0	0				6,247	6,247	CONTRAC	27,979	
7510		69,067	ACTIVITES WAGES	49,359	49,359	11	1	0	0				6,250	6,250	NURSE AII	3,585	
7540			ACTIVITIES SICK & VAC	0		11	1	0	0				6,255			835	
7590			ACTIVITIES SUPPLIES	3,719	3,719	11	2	0	0				6,260				
7595			ACTIVITIES FEES	3,408	3,408	11	3	0	0				6,270	6,270	REHAB WAGES		
7610			PT WAGES			39	1	0	0				6,275	6,275	REHAB PTO & RESERVE		
7611			PT SICK & VACATION			39	1	0	0				6,280	6,279	REHAB THERAPY COSTS		
7620			PT FEES	2,591		39	3	0	0 ***				6,290	6,290	NURSING	38,566	
7660			PT SUPPLIES	0		39	2	0	0				6,295	6,295	NURSING	11,091	
7710			SOCIAL SERVICE WAGES	9,757	9,757	12	1	0	0				6,390	6,390	REPLACEI	1,158	
7720			SOCIAL SERVICE SICK & VAC	0		12	1	0	0				6,490	6,490	OTHER	71	
7730			SOCIAL SERVICE EXPENSES	233	233	12	2	0	0				7,280	7,280	DRUG PURCHASES-MEDICARE		
7740			OT FEE	0		39	3	0	0 ***				7,281	7,281	DRUG PURCHASES-OTHER		
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0				7,380	7,380	LABORATORY SERVICES		
7770			SPEECH THERAPY FEE	0		39	3	0	0 ***				7,391	7,390	X-RAY SERVICES EXPENSE		
7800			BEAUTICIAN WAGES		0	40	1	0	0				7,393				
7810			BEAUTICIAN SICK & VAC			40	1	0	0				7,510	7,510	ACTIVITIE	49,359	
7820			BEAUTICIAN FEES	11,467	11,467	40	3	0	0				7,540	7,540	ACTIVITIES PTO & RESERVE		
7890			BEAUTY SHOP SUPPLIES	824	824	40	2	0	0				7,590	7,590	ACTIVITIE	3,719	
7910			VOLUNTEER COORDINATOR			21	1	0	0				7,595	7,595	ACTIVITIE	3,408	
7940			VOL COORD SICK & VAC			21	1	0	0				7,610				
7960			VOL COORD SUPPLIES	152		21	2	0	0				7,611				
8100			RENT	680	680	34	3	0	0				7,620	7,620	PHYSICAL	2,591	
8120			INTEREST EXPENSE	15,716	15,716	32	3	14	0				7,660	7,660	P.T. SUPPLY - BILLABLE		
8130			DEPRECIATION	22,965	22,965	30	3	9	0				7,710	7,710	SOCIAL SI	9,757	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	33,945			7,720	7,720	SOCIAL SERVICE PTO & RESERVE		
9510			INTEREST INCOME	-115		32	0	10	-115				7,730	7,730	SOCIAL SI	233	
9520			MISC NON-OPERATING INCOM	-3,822		0	0	0	0				7,740	7,740	OCCUPATIONAL THERAPY FEE		
9700			INCOME TAXES	4,540		0	0	0	0				7,750	7,750	SOCIAL THERAPIST FEE		
				2,047,845	2,047,242								7,770	7,770	SPEECH THERAPY FEE		
					-603								7,820	7,820	BEAUTICI	11,467	
GRAND TOTALS				52,326					-37,315				7,890	7,890	BEAUTY S	824	
				(NET INCOME)									7,910				
				0									7,940				
			FACILITY NAME:	OSF SAINT CLARE HOME									7,960			152	
			FACILITY ID:	0									8,120	8,120	INTEREST	15,716	
													8,125	8,125	ALLOCATED INTEREST EXP		
													8,130	8,130	DEPRECIA	22,965	
			FACILITY UNITS:	89									8,150				
													9,510	9,510	INTEREST	-115	
			BALANCE SHEET TOTAL	0									9,520	9,520	MISC NON	-3,822	
				-52,326									9,530		rent	680	
													9,700		bod fees	4,540	
																52,326	

	G/L	RECAP CENSUS
PP	9,583	9,583
IPA	10,080	10,080
medicare	0	0
	19,663	19,663
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	